



Bar-None Residential Treatment Services

22426 St. Francis Blvd.

Anoka, MN 55303

www.voamn.org

Phone 763-753-2500 Fax 888-965-5125

Referral Information Checklist

Please include the following information when making a referral to Bar-None.

- Completed referral information form
- Relevant legal documentation (custody papers, court orders)
- Copies of insurance cards
- Clinical information including:
 - Most recent Psychological /Psychiatric Assessment/Diagnostic Assessment (within the last 6 months)
 - Treatment summaries (hospital, day treatment, outpatient)
 - Psychological/Neuropsychological testing reports
- Most recent Individualized Education Program (IEP) and IEP Evaluation
- Immunization records

Send to:

Bar-None Residential Services
ATTN: Shelly Manke

Fax: 888-965-5125

Email: smanke@voamn.org

Mail: 22426 St. Francis Blvd.
Anoka, MN 55303



Bar-None Referral Information Form

Date:

| CLIENT INFO | | | | | |
|---|-----------|---------------------|--|--|--------|
| Name <i>(last, first, middle)</i> : | | | | Admission Unit: | |
| Nickname: | | DOB: | | Admit Date/Time: | |
| Age: | Sex: | Place of Birth: | | IQ: | SSN: |
| Court ordered: | Custody: | Adjudicated: | | Religious activities: <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Race: | Language: | Tribal affiliation: | | Spiritual affiliation: | |
| Primary Medical Doctor/Clinic: <small>(address & phone)</small> | | | Last school attended: <small>(address, phone & contact)</small> | | |
| SDRS: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A | | | District #: | | Grade: |
| REFERRING AGENT | | | | | |
| Name: | | County: | | Phone: | Fax: |
| REASON FOR REFERRAL | | | | | |
| Previous or current charges? | | | <input type="checkbox"/> Yes <input type="checkbox"/> No | Explain: | |
| Is the youth a danger to him/herself? | | | <input type="checkbox"/> Yes <input type="checkbox"/> No | Explain: | |
| If yes, have there been any recent or significant suicide attempts? | | | <input type="checkbox"/> Yes <input type="checkbox"/> No | Explain: | |
| Is the youth a danger to others? | | | <input type="checkbox"/> Yes <input type="checkbox"/> No | Explain: | |
| Chemical abuser and/or chemically dependent? | | | <input type="checkbox"/> Yes <input type="checkbox"/> No | Explain: | |
| Have there been any inappropriate sexual behaviors? | | | <input type="checkbox"/> Yes <input type="checkbox"/> No | Explain: | |
| If yes, is youth a sex offender? | | | <input type="checkbox"/> Yes <input type="checkbox"/> No | Explain: | |
| Is youth currently hallucinating or having delusions or any concerns of this within the last three months? | | | <input type="checkbox"/> Yes <input type="checkbox"/> No | Explain: | |
| Previous DA? | | | <input type="checkbox"/> Yes <input type="checkbox"/> No | Date: | |
| Where is youth currently? (name & address) <small>(Admissions from Rice Institute, Willmar Mon-Thurs due to 1 day of medication given upon discharge.)</small> | | | | | |
| Reason for referral/presenting problems: | | | | | |
| If evaluation, what specifically are you looking for? | | | | | |
| Youth strengths? | | | | | |
| Current medications, including injectable meds, and prescribing physician: | | | | | |
| Are they taking meds to manage seizures? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | Explain: | |
| Is the youth an insulin-dependent Diabetic? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | Explain: | |
| Hx of major illnesses, surgeries, broken bones? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | Explain: | |
| Any pending medical/dental appointments? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | Explain: | |
| Does the youth have any food/drug allergies? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | Explain: | |
| Does the youth need an Epi-Pen for any reason? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | Explain: | |
| Has the youth ever had a positive Mantoux? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | Explain: | |
| If you answered YES to any of the above medical questions, you will be contacted by our nurse prior to acceptance. | | | | | |

| COUNTY INFO | |
|---|--|
| Social Worker: Address: Phone: Fax: Email: | Probation Officer: Address: Phone: Fax: Email: |
| PARENT INFO | |
| Mother: Address: Phone: Email: DOB: | Father: Address: Phone: Email: DOB: |
| BILLING INFO | |
| Current MA # | MA Verified <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Insurance Info | Policy Holder's Name |
| ID/Policy # | Policy Holder's DOB |
| Group # | Relationship to Youth |
| Per Diem Billing (<i>county or insurance</i>) | Medical Billing (<i>insurance or MA</i>) |
| BAR-NONE MENTAL HEALTH SCREENING ASSESSMENT | |
| Person screening | |
| Diagnosis at Intake DSM V (ICD-10) | |
| How is the program able to meet the youth's needs? (<i>Cultural, emotional, educational, mental health, physical, etc.</i>): | |
| Do further assessments need to be completed such as the POSIT and/or Rule 25? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| <input checked="" type="checkbox"/> Complete all intake assessments | |
| <input type="checkbox"/> Other assessments, explain: | |
| Accepted for Program <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| If no, explain: | |
| Program recommended: | |
| COLLATERAL DOCUMENTATION | |
| | |
| | |

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